DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/23/16

PRINTED: 08/15/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 44E251 | A. BUILDING _____ B. WING _____ | 08/09/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENE MANOR MEDICAL CTR. | 970 WRAY ST KNOXVILLE, TN 37917 |

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| F 000 | INITIAL COMMENTS<br><br>During the Recertification survey and investigation of complaints #39241, #39242, and #39243 conducted on 8/7/16-8/9/16, at Serene Manor Medical Center, no deficiencies were cited in relation to the complaints under 42 CFR Part 483, Requirements for Long Term Care Facilities. | F 000 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and interview, the facility failed to ensure a resident received range of motion for 1 Resident (#76) of 29 residents reviewed.<br><br>The findings included:<br><br>Medical record review revealed the resident was admitted to the facility on 1/4/16, with diagnoses including CVA (Cerebrovascular Accident), Hemiplegia, Seizure Disorder and Depression.<br><br>Review of the Quarterly Minimum Data set (MDS) dated 4/18/16, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Continued review revealed impairment of one | F 318 | F 318 Increase/Prevent Decrease Range of Motion: Corrective action will be accomplished for Residents found to have been affected by the deficient practice.<br><br>1. Resident #76 now has an order for range of motion to the right side of upper and lower extremities by primary nursing staff daily.<br>2. Other Residents identified having the potential to be affected by the same deficient practice are all Residents who have suffered a stroke or have a contracture have been assessed and now have an order for range of motion daily by primary nursing staff specific to the area of their body affected. | 9-23-16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rita Griffin — TITLE: Administrator — (X6) DATE: August 26, 2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 318 | Continued From page 1<br>side of the upper and lower extremity.<br><br>Review of the Resident Summary dated 4/19/16 revealed "...Paralyses right hand and right leg..."<br><br>Review of the Resident Summary dated 6/10/16, revealed "...Comments Paralysis R [right] Hand, R leg..."<br><br>Review of the Care Planning Meeting dated 7/21/16 revealed "...R sided Hemiplegia with weakness..." Continued review revealed no documentation to address the resident's right sided weakness.<br><br>Observation on 8/7/16 at 11:29 AM, revealed Resident #76 sitting in her wheelchair (w/c) in her room. Continued observation revealed right sided weakness of right arm and right leg. Further observation revealed the resident did not have a splint in place.<br><br>Telephone interview with the Medical Director on 8/9/16 at 10:00 AM, confirmed neither a splint nor physical therapy had been ordered for the resident.<br><br>Interview with Unit Manager #1 on 8/9/16 at 10:15 AM in the 200 hallway, confirmed the facility failed to provide range of motion, a splint or physical therapy for Resident #76. | F 318 | 3. Measures put into place/systematic changes made to ensure the deficient practice does not recur are all Residents who have suffered a stroke or have contractures will be assessed by nursing staff and an order will be requested from the attending physician for range of motion, a splint, or physical therapy at the time of admission, after a change in physical condition, and at each quarterly care plan meeting according to Facility procedures. An in-service was conducted August 16, 2016 and this procedure will be in-serviced annually.<br><br>4. Corrective action will be monitored to ensure the deficient practice does not recur by Director of Nursing or designee and Quality Assurance Nurse monthly for the next six months to assure education has been implemented. Monitoring will be accomplished in part by discussions with Nurse Supervisors and Primary Caregivers at each stand-up meeting conducted. Also, will be discussed at the next scheduled Quality Assurance Meeting. | |
| F 371 ss F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and | F 371 | F371 Food, Procure, Store/Prepare/ Serve-Sanitary Corrective action will be accomplished for those Residents to be affected by the deficient practice. | 9-23-16 |

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| F 371 | Continued From page 2<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility policy, observation, and interview, the facility failed to date a prepared salad, secure opened foods, monitor expired foods, clean 1 of 2 walk-in refrigerators duel cooling fans, maintain clean kitchen equipment for 1 of 1 kitchen and maintain thermometers for 1 of 2 resident refrigerators reviewed, affecting 28 of 72 residents.<br><br>The findings included:<br><br>Review of the facility policy, Food Storage, dated 2010, revealed "...prepared food ...must be dated, labeled, covered ...within 3 days ..." Further review revealed "...food service equipment should be cleaned, sanitized, dried, and reassembled after each use..." Continued review revealed "...date marking ...should be consumed, sold, or discarded ..."<br><br>Review of the facility policy, Food Temperatures, dated 2010, revealed "...unit refrigerators will be monitored for temperatures ...at or below 41 degrees F [Fahrenheit] ..."<br><br>Observation on 8/7/16 at 9:10 AM with the Dietary Manager (DM), in the walk-in refrigerator, revealed an undated, pan of prepared coleslaw. Continued review revealed an unsecured, opened bag of grated cheddar cheese. Further | F 371 | 1. Food in the walk-in refrigerator or in the dry storage room is dated, opened food is secured, and out of date bread has been discarded. Equipment is clean including the duel cooling fan in the walk-in refrigerator and stand-up mixer. A thermometer is in the 3rd floor resident refrigerator and is monitored daily by Dietary staff for correct temperature range.<br>2. Other Residents having the potential to be affected by the same deficient practice are the Residents on 3rd floor. Corrective action taken is misplaced thermometer was replaced in the refrigerator for proper monitoring by Dietary staff for correct temperature range. Kitchen equipment is clean Packaged food and prepared food in the walk-in refrigerator and dry storage room is dated, secured, and in date.<br>3. Measures put into place or systematic changes made to ensure the deficient practice does not recur is a performance improvement plan has been implemented with education that includes a. Fan in the walk-in refrigerator added to the Dietary cleaning schedule b. Audit by Director of Food Service or designee with daily checklist documentation for compliance of securing opened packages in the dry storage room, refrigerator temperatures shall be in range, prepared food shall be dated in the walk-in refrigerator, out of date bread shall be discarded, and Kitchen equipment shall be clean. | |

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| F 371 | Continued From page 3<br>observation revealed a duel cooling fan with dust debris.<br><br>Observation on 8/7/16 at 9:20 AM with the CM, in the Condiment/Bread /Dry Storage Room, revealed the following unsecured opened breads: 2 packages of hamburger buns and 1 package of dinner rolls (ripped open). Continued observation revealed the following expired breads dated 8/5/16: 1 package of dinner rolls and 1 bag of sliced bread. Further review revealed 1 unsecured, opened bag of mini marshmallows.<br><br>Observation with the CM on 8/7/16 at 9:25 AM at the covered stand-up mixer, revealed dried white debris on the rim and top of the mixer.<br><br>Observation with the CM on 8/8/16 at 9:30 AM on the 3rd floor, at the resident refrigerator.revealed no thermometer in the refrigerator or the freezer. Continued observation revealed fruit pops in the freezer and puddings, thickened fruit juices, and thickened water in the refrigerator.<br><br>Interview with the CM on 8/7/16 at 9:30 AM in the kitchen, confirmed the facility failed to date and label the prepared coleslaw, to secure opened foods, to discard expired foods, to maintain clean kitchen equipment, and to clean the duel cooling fan.<br><br>Interview with the CM on 8/8/16 at 9:30 AM at the 3rd floor resident refrigerator, confirmed the facility failed to maintain and monitor the temperatures of the resident refrigerator/freezer.<br><br>Interview with the Administrator on /8/8/16 at 4:45 PM in the Administrator's office, confirmed the facility failed to maintain the cleanliness of the | F 371 | 4. Monitoring of corrective action to ensure the deficient practice will not recur will be accomplished by Director of Food Service, Quality Assurance, and Administrator or designee on a daily basis. Monitoring will be accomplished by a compliance review of the checklist and personal inspection of the 3rd floor refrigerator and walk-in refrigerator. This action plan will be discussed for compliance in the next scheduled quarterly quality assurance meeting for continued compliance. | |

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| F 371 | Continued From page 4<br>cooling fans. | F 371 | | |
| F 441 ss D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | F441 Infection control, prevent spread, Linens<br>1. Corrective action accomplished for the deficient practice is education for all licensed staff specifically addressing donning gloves before administering any injection.<br>2. Other Residents identified having the potential to be affected by the same deficient practice are any Residents who required an injection. Corrective action is education for all licensed staff specifically addressing donning gloves prior to administering any injection.<br>3. Systematic Changes made to ensure the deficient practice does not recur is a requirement for all licensed nurses to attend an annual education regarding infection control which will specifically address donning gloves prior to administering injections.<br>4. Corrective action will be monitored by Director of Nursing and Quality Assurance Nurse or designee by walk thru observations of injection administration periodically and at least monthly for six months to assure continued compliance. | 9-23-16 |

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| F 441 | Continued From page 5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, observation and interview the facility failed to ensure staff don gloves before administration of an injection for 1 of 31 opportunities observed for medication administration.<br><br>The finding included:<br><br>Review of the facility policy Medication Administration revised 8/15 revealed "...With administration of any injection for example insulin, IM [intramuscular] ABT [antibiotic], etc. gloves must be applied prior to injection being given..."<br><br>Observation of Licensed Practical Nurse (LPN) #2 on 8/7/16 at 12:05 PM, in a resident's room revealed LPN #2 prepared 5 units of Novolog (medication to decrease blood sugar) insulin and proceeded to administer the insulin injection to the patient without donning gloves.<br><br>Interview with LPN #2 on 8/7/16 at 12:07 PM, on the 200 hallway, confirmed she failed to don gloves before administering the insulin injection.<br><br>Interview with the Director of Nursing (DON) on 8/7/16 at 3:45 PM, in the DON's office, confirmed the facility failed to use Personal Protective Equipment (PPE) to maintain appropriate infection control practices. Continued interview confirmed staff are to don gloves before administering injections. | F 441 | | |